



ANNUAL REPORT OF COMPREHENSIVE LONG TERM CARE FACILITY

State Form 50834 (2-02)

INDIANA STATE DEPARTMENT OF HEALTH

Year: _____

I. Facility Identification

Facility Name	
Street Address	

City		Zip Code	
County		Township	

Administrator Name	
Former Name of Facility	
Person Completing Form	
Open the entire year (yes/no)	

Owner's Name	
Owner's Address	

Type of Ownership (check one below)

For Profit Individual	For Profit Partnership	For Profit Corp	Nonprofit Church	Nonprofit Corp	State	County

Type of Specialized Units

	Number of Beds	Census December 31 st
HIV		
Alzheimer's		
Head Trauma Unit		
Pediatric Unit		
Ventilator Unit		

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II. Comprehensive Beds

DATE	TOTAL LICENSED BEDS	CERTIFIED BEDS	NON -CERTIFIED BEDS
January 1 st			
December 31st			

III. Addition/Removal of Comprehensive Beds

Added Beds		Certified Beds	Non-Certified
	# of Beds		
	Month Changed		
Removed Beds			
	# of Beds		
	Month Changed		

IV. Comprehensive Resident Days by Source of Reimbursement for calendar year

PAYMENT	CERTIFIED	NON-CERTIFIED	TOTAL
Private Pay			
Medicare			
Medicaid			
Other			
Total			

V. Comprehensive Resident Days by Age for calendar year

Certification	> 65 Years	65-74 Years	75-84 Years	85+ Years	Total
Certified					
Non-certified					
Total					

VI. Comprehensive Residents by Age and Sex (Census as of December 31, 2000)

Age Group	Male Residents	Female Residents	Total Residents
0-19 Years			
20-39 Years			
40-64 Years			
65-75 Years			
75-84 Years			
85 + Years			
Total			

VII. Annual Admissions to Comprehensive Care Facility

Source of Referrals	Total Residents
Independent / Self Care	
Family	
Hospital	
Mental Health Center	
Home Health Agency	
Another Nursing Home	
Other	
Total	

VIII. Annual Discharges from Comprehensive Care Facility

Discharged to	Total Residents
Independent Self Care	
Family	
Hospital	
Mental Health	
Another Nursing Home	
Death	
Other	
Total Discharges	

Comments

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